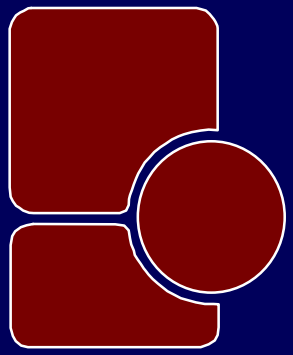
Joint Legislative Audit and Review Commission
of the Virginia General Assembly



Review of the Medicaid Inpatient Hospital Reimbursement System

Staff Briefing
November 13, 2000

Introduction

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Presentation Outline

- ☑ Study Overview and Summary of Findings
- ☐ Background on Medicaid Rate-Setting for Inpatient Care
- ☐ Current Rate-Setting Methodology for Medicaid Inpatient Care
- ☐ Process Used By DMAS to Set Rates for Medicaid Inpatient Care
- ☐ Adequacy of Payment Rates for Medicaid Inpatient Care

Study Mandate

- In 1996, the General Assembly placed language in the Appropriation Act requiring the Department of Medical Assistance Services (DMAS) to make fundamental changes to its payment system for Medicaid inpatient care.
- Four years later, in response to concerns raised by the hospital industry, the General Assembly passed Item 20K of the 2000 Appropriation Act, directing JLARC to examine both the process and methodology used by DMAS to establish this new payment system.

Study Mandate

- **Some of the specific requirements of the mandate required JLARC staff to conduct the following activities:**
  - **A comparison of Virginia's reimbursement system for inpatient hospital care with those of other states**
  - **An assessment of the accuracy of the claims database used by the department to make payments to hospitals**
  - **An assessment of the adequacy of current hospital rates, including whether they afford hospitals a reasonable opportunity to recover their costs.**

Research Activities

- Structured interviews with staff at DMAS
- Analysis of patient claims data from DMAS and Virginia Health Information (VHI)
- Survey of other states
- Review of State regulations and documents

Summary of Findings

- The rate-setting methodology implemented by DMAS is generally logical and internally consistent, while containing all the key elements necessary to calculate rates for inpatient hospital care.
- However, in establishing this new system, DMAS experienced a number of technical and implementation problems that considerably delayed the rate-setting process and lowered hospital payments.
- DMAS did not meet originally established timeframes for the rate-setting process. As a result:
  - Hospitals were informed of the new DRG rates 16 months late
  - The intent of the General Assembly as provided in the Appropriation Act (that rates be published prospectively) was not met.

Summary of Findings
(continued)

- **Technically, DMAS experienced two problems that affected hospital payment rates.**
  - **When setting payment rates for FY 1999, DMAS used a method that was later determined to have lowered hospital payments, necessitating a $12 million appropriation from the General Assembly in FY 2000 to compensate hospitals for revenues lost as a result of this problem.**
  - **The databases used by DMAS caused some patient claims to be inappropriately categorized and resulted in underpayments to some hospitals. Fixing this problem could cost a minimum of $11.4 million.**

Summary of Findings
(continued)

- Finally, since 1996, hospitals in Virginia have reduced the length of time that Medicaid patients are hospitalized, and have limited the growth rate for the real cost of care to less than two percent annually.

- Despite these trends, the payment rates for private hospitals have been adjusted downward in each year since FY 1998 based on an agreement established with the industry. Accordingly, Virginia's payment levels to hospitals are among the lowest in the country.

Summary of Findings
(continued)

- If the adjustments applied to hospital payments were eliminated, operating payments to private hospitals would increase by an estimated $48 million.

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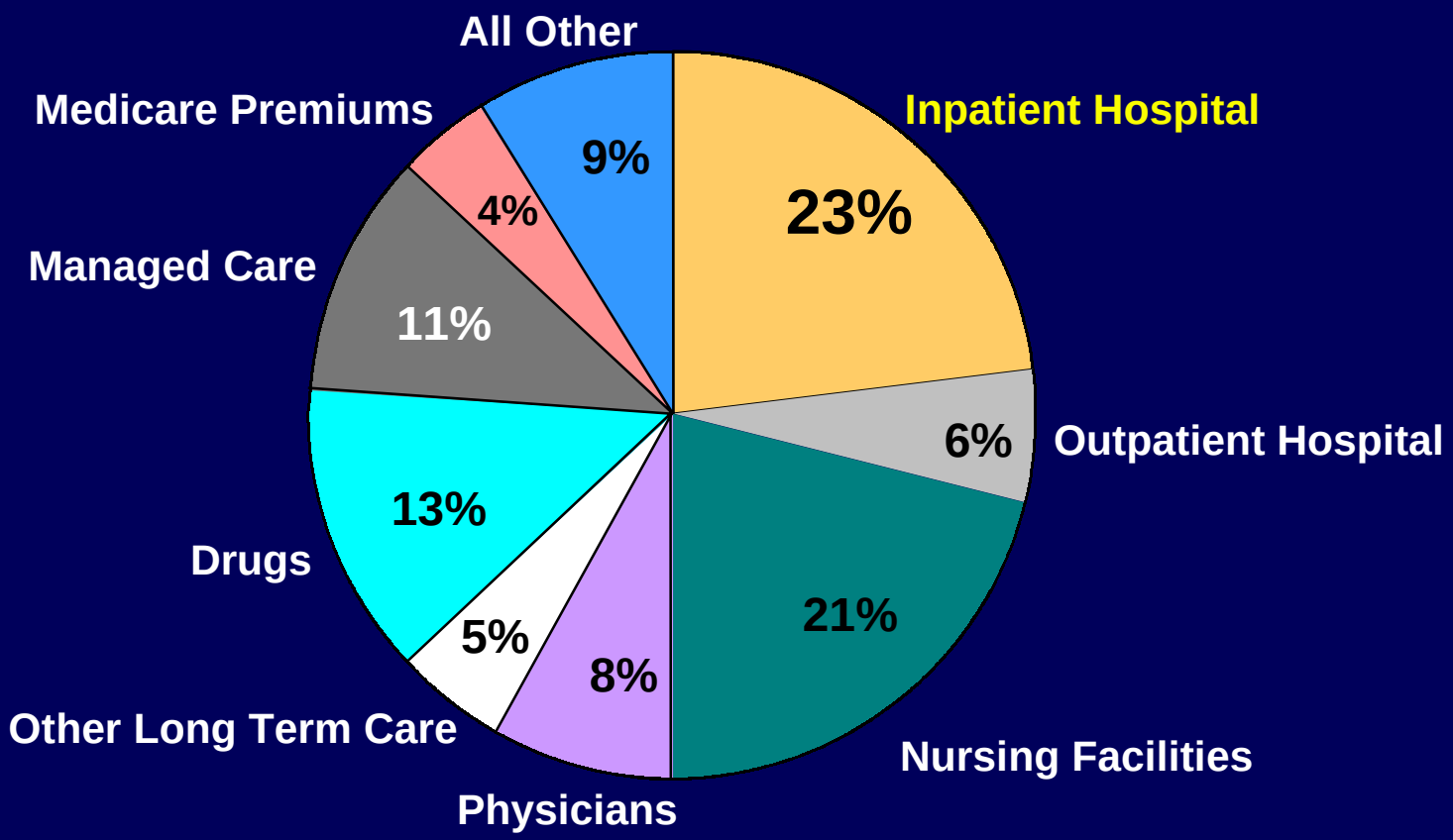
Background

- Medicaid is a healthcare program jointly financed by the federal government and the states to provide a range of services for the poor.
- Presently, there are four types of major medical services that are funded by the Virginia Medicaid program under the general category of inpatient care. They are:
  - Acute care
  - Rehabilitation hospital services
  - Long-stay hospital services
  - Inpatient psychiatric care

Inpatient Hospital Care Accounts for 23 Percent of Total Medicaid Spending

Medicaid Expenditure by Major Programs, FY 1999
(Total Expenditures = $2.047 Billion)



Over the Years, Virginia Has Used Three Different Payment Systems for Inpatient Care

Years	System Design	Unit of Payment	Cost Controls
1969-82	Retrospective system. Hospitals reimbursed 100 % of costs.	Allowable Costs	None
1983-96	Prospective System. Inpatient rates established before services provided.	Per-Diem Operating Cost	Payment Ceilings
1996-Present	Prospective System. Inpatient rates established before services provided.	Per-Patient	Payment based on expected length of treatment. Also, adjustment factor used

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General Assembly Creates Advisory Council to Develop Recommendations for New Payment System

- In 1996, the General Assembly passed budget language creating the Medicaid Payment Policy Advisory Council (the council) to work on the development of a new payment system.
- The council includes representatives from DMAS, the hospital industry, the Department of Planning and Budget, and the Joint Commission on Health Care.

DRG Payment Methodology Developed by DMAS Accounts for Patient-Mix and Differences in Hospital Labor Costs

Basic Methodology of a Diagnosis Related Group (DRG) Reimbursement System

DRG Payment = Relative Weight X Hospital Base Operating Rate

- **DRG Payment**: Per patient payment
- **Relative Weight**: The cost of treating a patient in a particular DRG compared to the costs of treating patients in all other DRGs
- **Hospital Base Operating Rate**: Average cost of treating a Medicaid patient in Virginia adjusted for a measure of the hospital's labor costs

Examples Using DRG Payment System

- **Normal Birthweight Delivery**

DRG Payment	=	Relative Weight	X	Hospital Base Operating Rate
$406	=	0.1473	X	$2,757

- **Newborn with Multiple Problems**

DRG Payment	=	Relative Weight	X	Hospital Base Operating Rate
$40,394	=	14.6515	X	$2,757

DMAS Rebases Its System Every Three Years

- Rebasing is a process of recalculating all parts of the DRG rates using more recent data. In an environment of rising medical costs, rebasing has the effect of increasing DRG rates because the new rates will be based on the higher cost.

- Currently, Virginia rebases the system every three years. In the interim, DMAS adjusts the rates using a hospital inflator.

State's Rebasing Policy Is Appropriate

- The study mandate requested JLARC to examine the appropriateness of the State's rebasing policy.
- Four of the 23 other states that have similar payment systems also rebase every three years. Eight other states allow no more than two years to elapse before rebasing. Nine states have no rebasing policy.
- In light of the administrative burden of rebasing, and DMAS' decision to inflate payments in years in which the system is not rebased, the State's current policy is appropriate.

Efforts to Make Virginia's Medicaid Inpatient Care System Budget Neutral Have Lowered Hospital Payment Rates

- In 1996, as a part of a settlement of litigation over the adequacy of the State's Medicaid payment system for inpatient care, the advisory council agreed to pursue two principal objectives when designing the new system.
  - First, the system should be "budget neutral." In other words, it was agreed that the rates for the new system should be calculated so that the "system-wide amount of the reimbursement would not be altered solely by the implementation of the new rate setting methodology."
  - Second, the system should be designed to stop the decline in the rate at which operating costs were reimbursed, which had characterized the system in the 1980s.

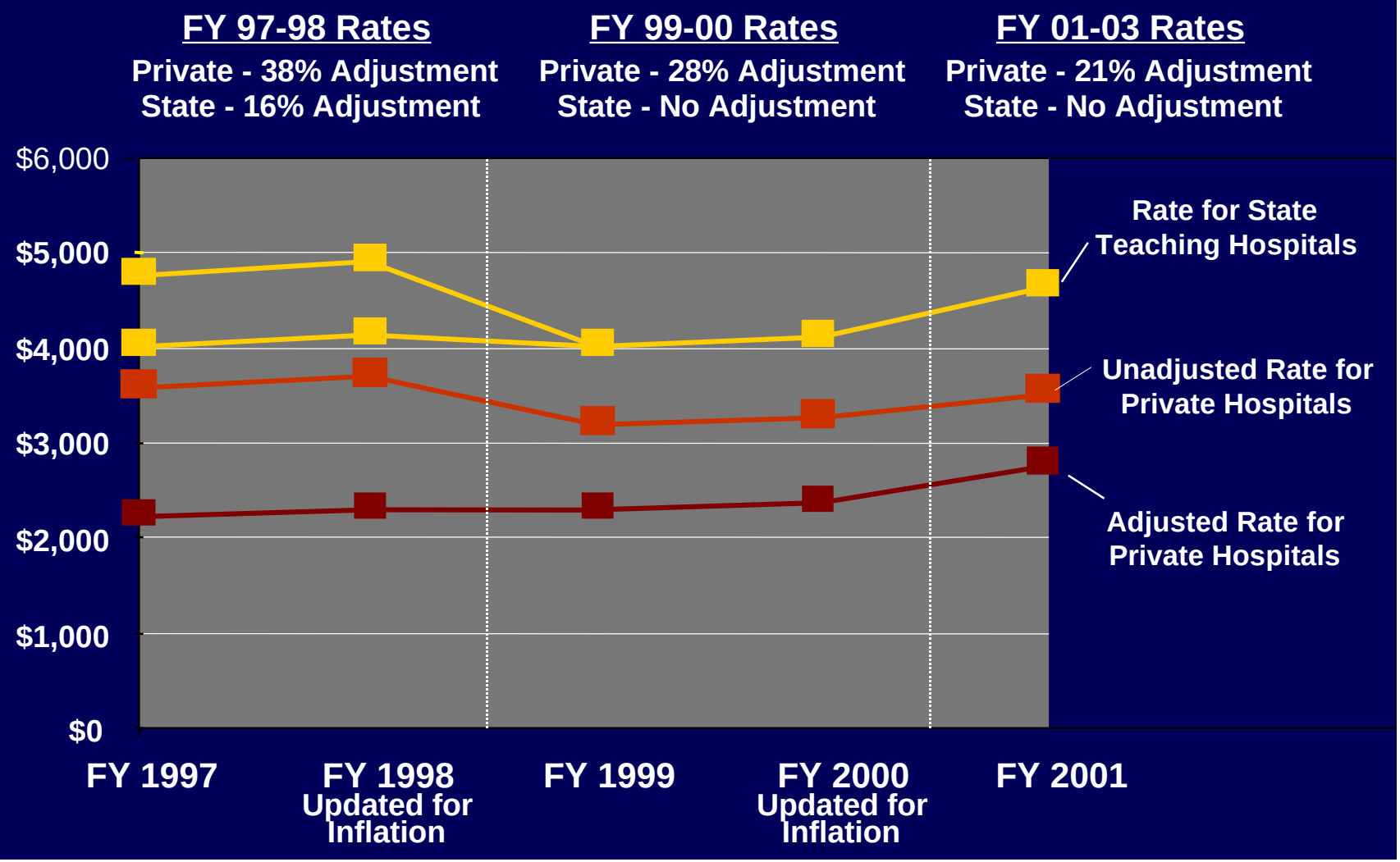
Efforts to Make Virginia's Medicaid Inpatient Care System Budget Neutral Have Lowered Hospital Payment Rates (continued)

- To accomplish these objectives, it was agreed that when all Medicaid payments were considered, the new system should cover 75 percent of hospital costs in 1996.
- To achieve this funding target through the application of a hospital payment rate, the Task Force agreed to reduce the average hospital base operating rate by 38 percent.
- In future years, the size of this adjustment factor for the new rates would be based on the ratio of operating costs reimbursements for each hospital to total operating costs, using data from a time period prior to the rebasing.

Adjustment Factor Has Reduced Hospital Payments by an Average of 21 to 38 Percent Since the Transition to the New System Began

Year Factor Applied	Method of Calculation	Payment Reduction	Data Used
FY 1997 FY 1998	Estimated rate of reimbursement for a select group of hospitals	38 percent	1993 costs 1993 patient claims data
FY 1999 FY 2000	Ratio of operating costs reimbursements to total operating costs	28 percent	1997 patient claims data Trended cost data from 1991 to 1995
FY 2001 FY 2002 FY 2003	Ratio of operating costs reimbursements to total operating costs	21 percent	1998 costs 1998 patient claims data

Adjustment Factor Has Reduced Hospital Payments by an Average of 21 to 38 Percent Since the Transition to the New System Began (continued)



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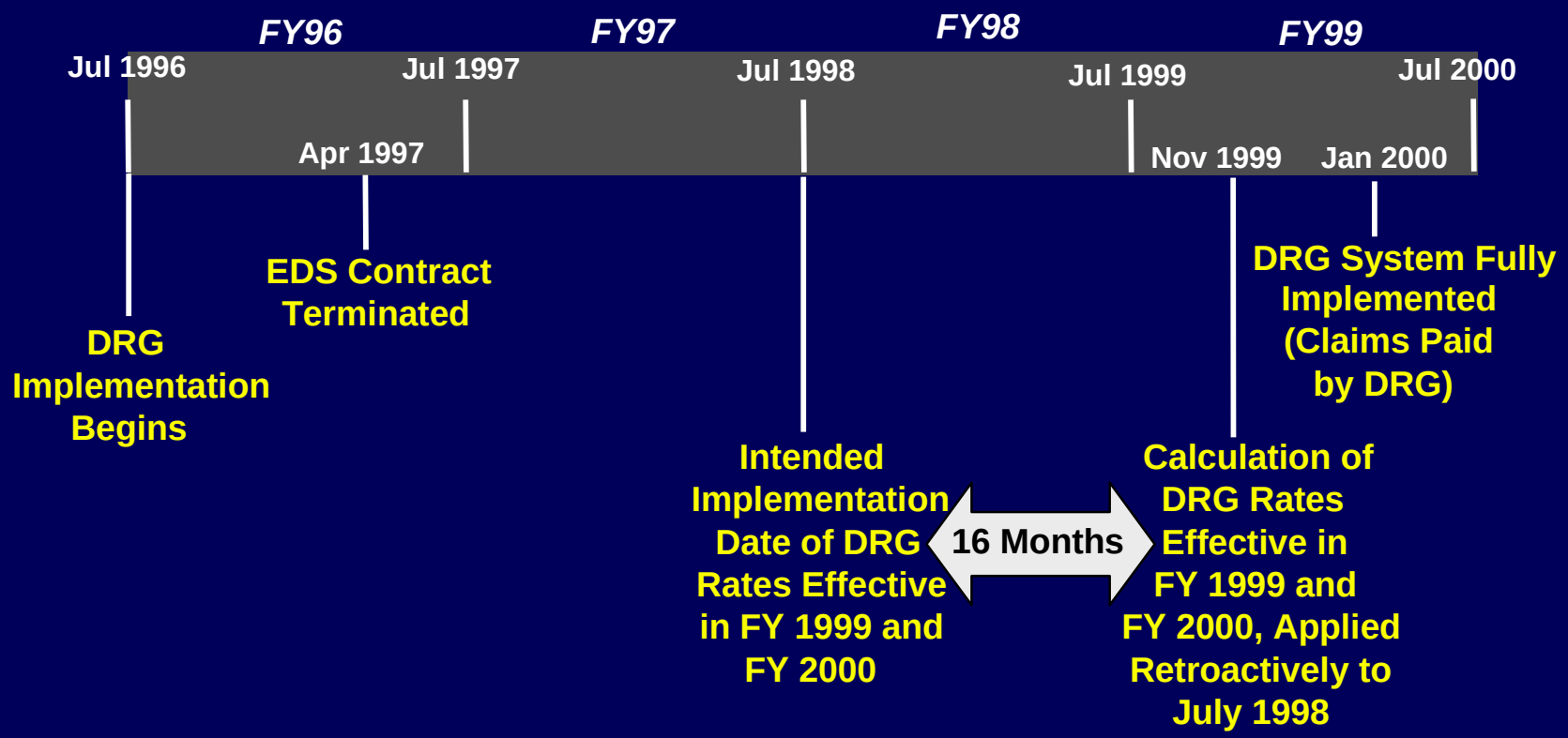
In Transitioning to the New System, the General Assembly Required DMAS to Implement a Fully Prospective DRG System

- Through Item J of the 1996 Appropriation Act, the General Assembly established two requirements for the new system:
  - Reimbursements were to be based on patient diagnosis.
  - The reimbursement rates were to be published prospectively -- before the hospitals provided the services.
- Currently, the DRG system is fully implemented with rates published prospectively. However, over a three-year period, the department experienced a number of problems in putting the system in place.

Problems with Contractor Required DMAS to Establish Initial DRG Rates Retroactively

Implementation of the DRG System Timeline



DMAS Needs to Clarify Role of the Council

- There is disagreement among members of the council regarding its appropriate role:
  - Hospital administrators assert that the council has the authority to vote on recommendations to the Board of Medical Assistance Services based on budget language passed by the General Assembly.
  - Representatives from DMAS note that current regulations state that the "council will be charged with evaluating and developing recommendations on payment policy changes" but does not specify to whom the recommendations should be made.

Recommendation

- The Department of Medical Assistance Services should better define the role of the Medicaid Payment Policy Advisory Council.

DMAS Made Several Errors During the Implementation of the New System

- The claims data used by DMAS to calculate DRG payments for hospitals under the new system was flawed because the data management system did not accept all of the information submitted for some of the more expensive patient claims.
- This meant that the severity of illness for some patients was underestimated and the hospitals received an underpayment for those cases.

The Cost of Correcting this Problem Could Be at Least $11.3 Million

Additional Payment Owed to Hospitals for Affected Cases

	FY 1997	FY 1998
DRG payment for affected cases based on the JLARC assigned AP-DRG (incorporating all diagnosis and procedure information)	$10,325,222	$16,390,360
DRG payment for affected cases based on DMAS assigned AP-DRG	$8,564,742	$6,761,257
The difference is the additional payment owed to hospitals	$1,760,480	$9,629,103

Total for fiscal years 1997 and 1998 — **Total = $11,389,583**

Current Regulations Do Not Permit DMAS to Reduce Payments to Hospitals from FY 1997 and FY 1998

- In FY 1995, the General Assembly reduced DMAS' budget by 16 million for anticipated savings due to reductions in the length-of-time Medicaid recipients would be hospitalized.
- DMAS subsequently promulgated regulations stating that the DRG rates that were effective in the transition year could be adjusted by up to $16 million if it were demonstrated that savings occurred in this amount that were "directly attributable" to State policy changes regarding length-of-stay.
- Based on these regulations, DMAS proposes a $1.4 million payment reduction to hospitals.

Current Regulations Do Not Permit DMAS to Reduce Payments to Hospitals from FY 1997 and FY 1998 (continued)

- There are two problems with DMAS' planned reduction in payments to hospitals based on changes in length-of-stay.
  - First, the methodology used by the department and the resulting outcomes fall considerably short of the burden of proof required by the regulations.
  - Second, the regulations require that the savings be applied as a reduction in DRG rates for FY 1997 and FY 1998, not a reduction in payments to hospitals during the transition years. This would require DMAS to reopen cost settlements for hospitals that have been closed for as many as four years.

Recommendation

- The Department of Medical Assistance Services should refrain from reducing the payment rates in effect in FY 1997 and FY 1998 based on changes in the length-of-stay for Medicaid recipients of inpatient care.

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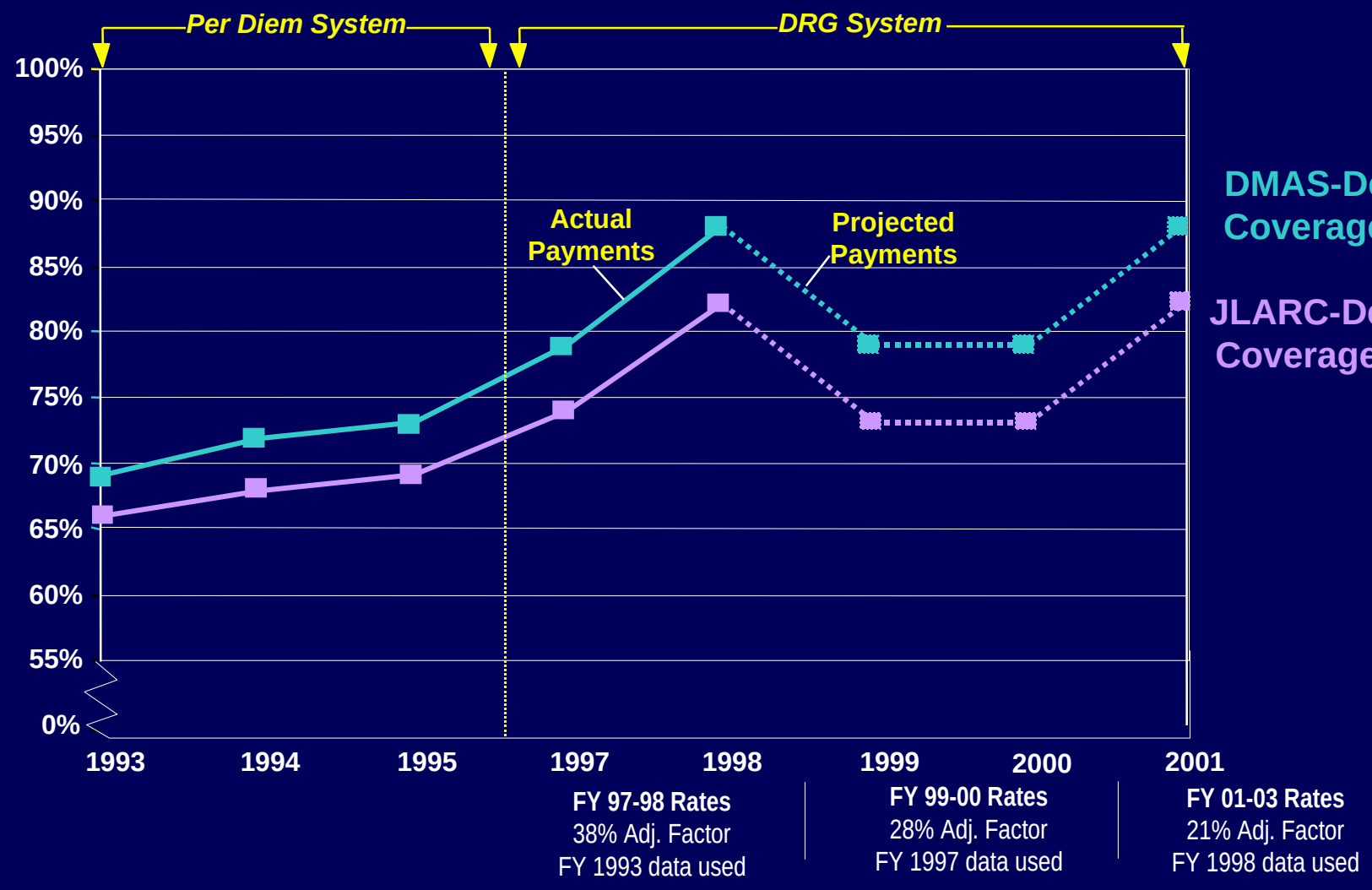
- ☑ **Adequacy of Payment Rates for Medicaid Inpatient Care**

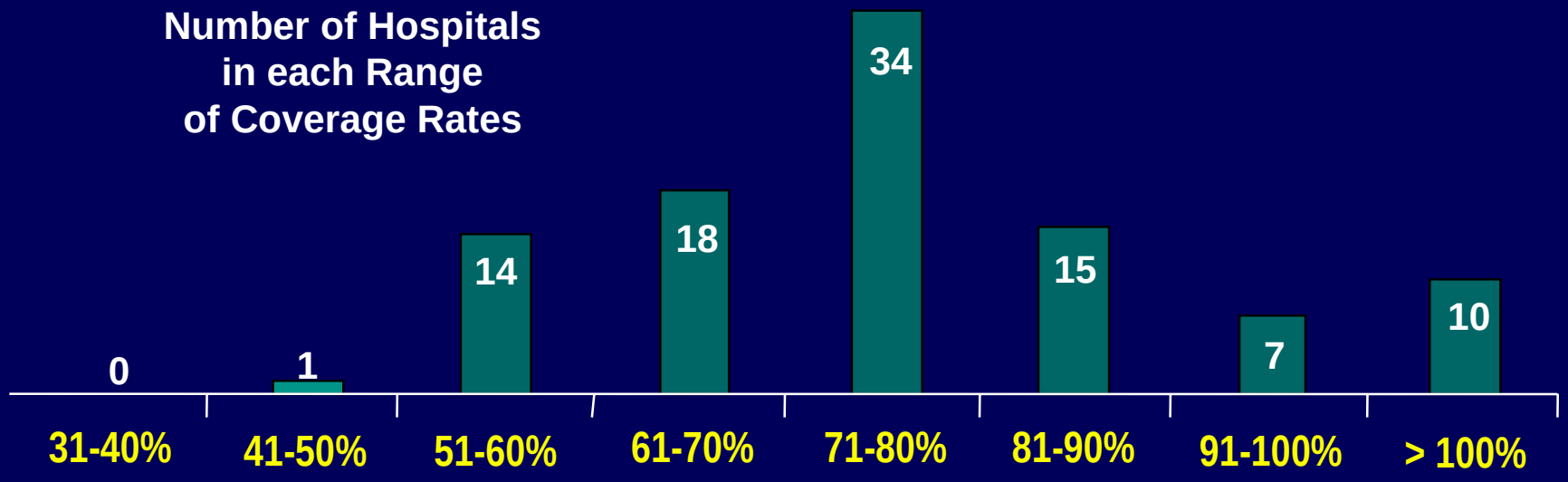
No Legal Standard Available to Assess Rate Adequacy for Inpatient Care

- When the Boren amendment was repealed by the United States Congress, the legal standard available to Virginia for evaluating the adequacy of its payments for inpatient care was eliminated.
- Now, both DMAS and the hospital industry agrees that the cost coverage rates -- the portion of a hospital's Medicaid allowable costs that is covered by total Medicaid payments -- is one way to reasonably assess the adequacy and impact of the reimbursement system.

Considerable Variation Exists in Average Medicaid Coverage Rates for Private Hospitals



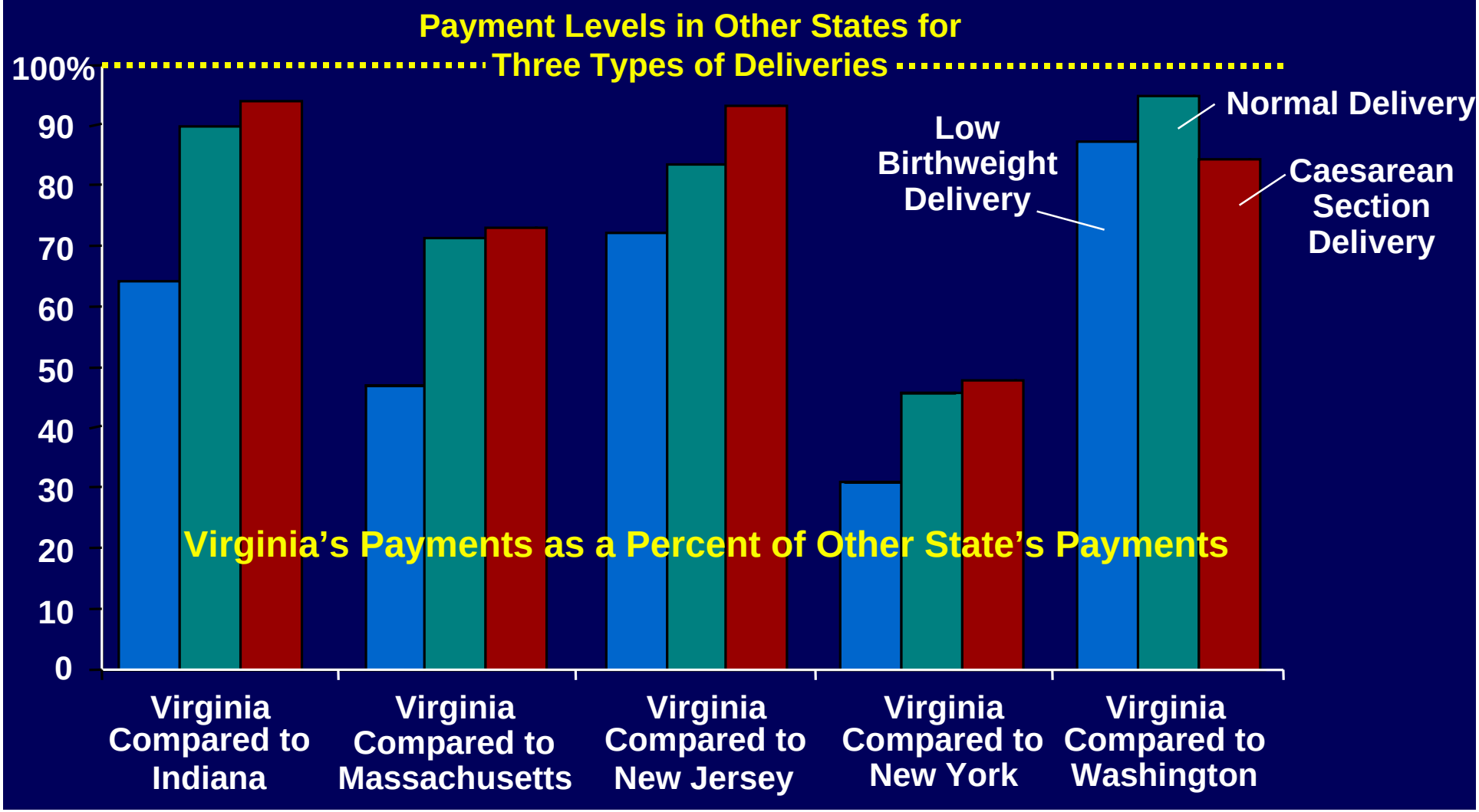
There is a Broad Range of Coverage Rates for Private Hospitals



Coverage Rates
for Hospitals in FY 1998
Using the JLARC Definition of Coverage

101 Private Hospitals
Average Coverage Rate = 81%

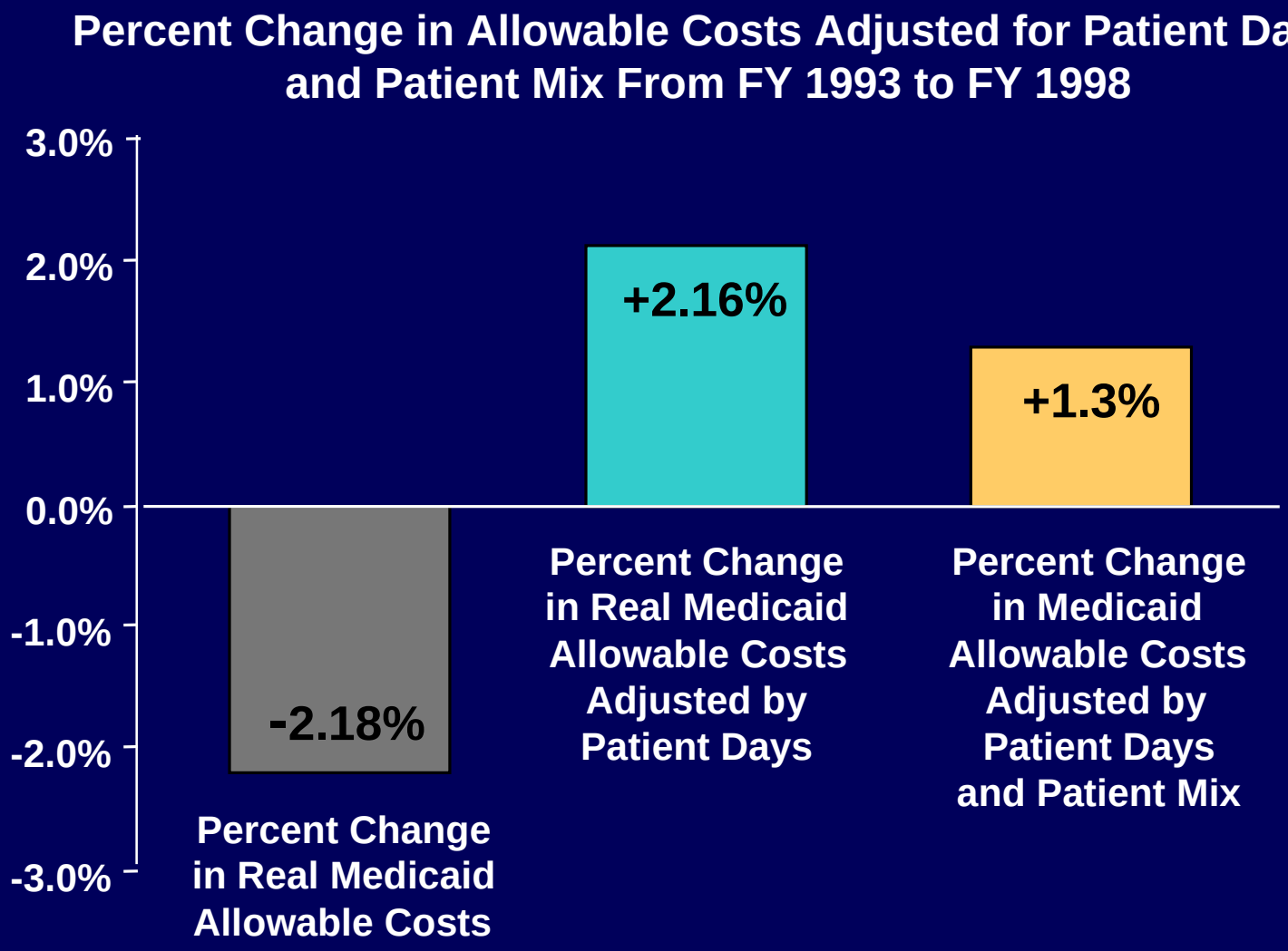
Virginia Pays Less for Medicaid Inpatient Care than Other States with Similar Systems



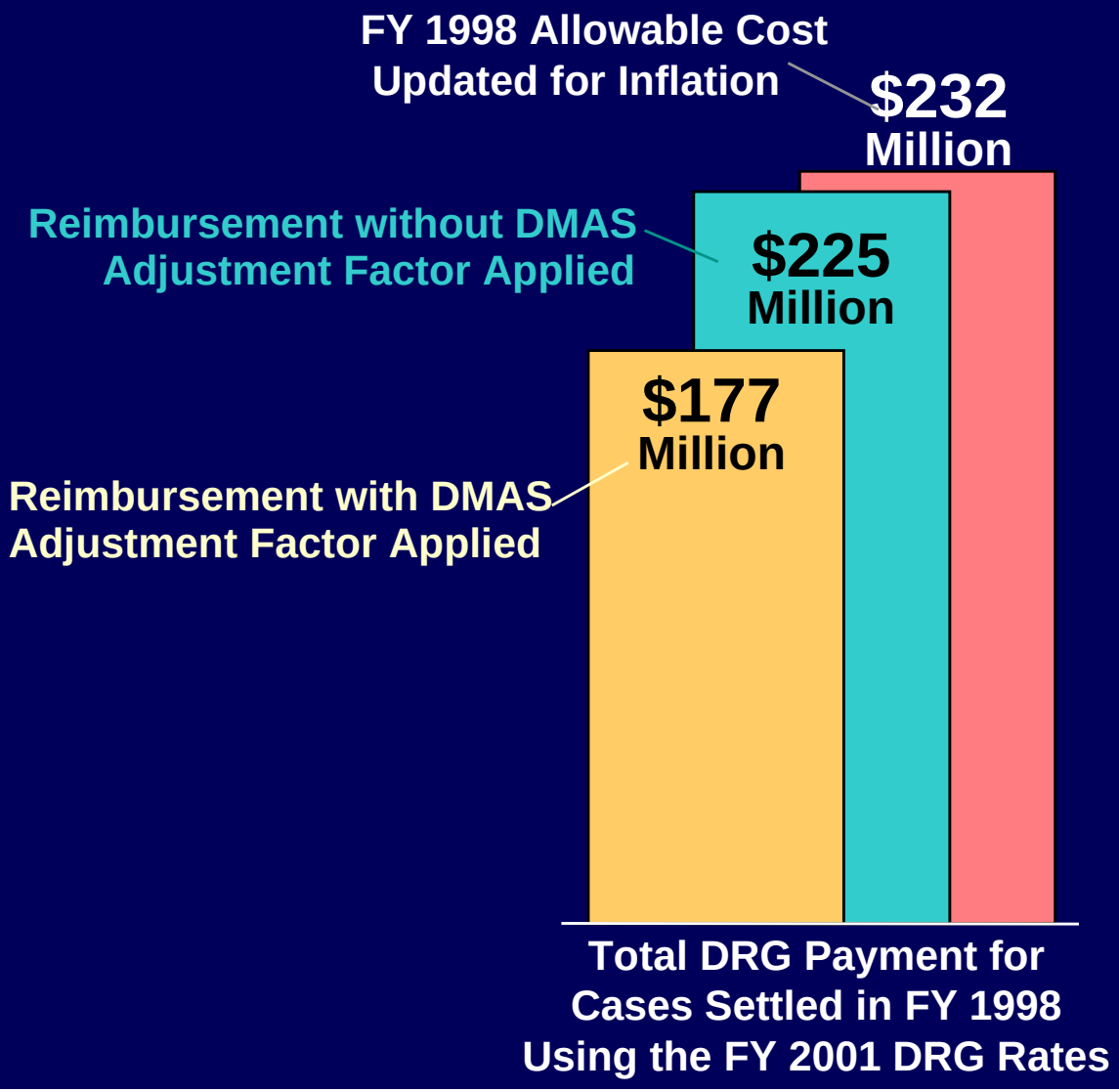
The Agreement Developed by Medicaid Advisory Council Requires State to Revisit Use of Adjustment Factor

- The Task Force report developed by the Medicaid Advisory Council in 1996 cited two reasons supporting the State's rate adjustment factor:
  - To protect the State from a surge in the cost of inpatient care.
  - To halt the erosion in Medicaid payments relative to cost for hospitals.
- In this same report, the council stated that the use of the adjustment factor should be revisited if they were demonstrable changes in several factors, including hospital efficiency.

The Continued Use of a Rate Adjustment Factor for Medicaid Inpatient Care Services Is Not Supported by Trends in Hospital Costs



Removing the Rate Adjustment Factor Will Increase Operating Payments to Hospitals by an Estimated $48 Million



Recommendation

- Prior to February 1, 2001 the Department of Medical Assistance Services should submit a plan to the House Appropriation and Senate Finance Committees outlining a strategy to phase out the rate adjustment factor by FY 2003.

Conclusion

- Rate-setting methodology implemented by DMAS is generally sound and appropriate.
- However, in establishing the new system for setting rates, DMAS experienced a number of implementation problems that delayed the process and lowered hospital payments.
- Databases used by DMAS caused some patient claims to be inappropriately categorized, resulting in underpayments.
- DMAS' use of an "adjustment factor" artificially lowers payments to hospitals and no longer appears justified as a component of the State's DRG system.